

Complete Summary

GUIDELINE TITLE

Management of heart failure in special populations: HFSA 2006 comprehensive heart failure practice guideline.

BIBLIOGRAPHIC SOURCE(S)

Heart Failure Society of America. Management of heart failure in special populations. J Card Fail 2006 Feb; 12(1):e115-9. [50 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Heart Failure Society of America. Heart Failure Society of America (HFSA) practice guidelines. HFSA guidelines for management of patients with heart failure caused by left ventricular systolic dysfunction--pharmacological approaches. J Card Fail 1999 Dec; 5(4): 357-82.

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SCOPE

DISEASE/CONDITION(S)

Heart failure

GUIDELINE CATEGORY

Management
 Treatment

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations for the management of heart failure in special populations

TARGET POPULATION

Elderly patients, women, and African Americans with heart failure

INTERVENTIONS AND PRACTICES CONSIDERED

1. Evaluation of elderly patients with symptoms of dyspnea and fatigue
2. Medications used alone or in combination, including:
 - Beta-blockers
 - Angiotensin-converting enzyme inhibitors
 - Angiotensin receptor blockers
 - Hydralazine and isosorbide dinitrate

MAJOR OUTCOMES CONSIDERED

- Morbidity and mortality
- Hospitalization
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Databases searched included Medline and Cochrane. In addition, the guideline developers polled experts in specific areas for data.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Level A: Randomized, Controlled, Clinical Trials
May be assigned based on results of a single trial

Level B: Cohort and Case-Control Studies
Post hoc, subgroup analysis, and meta-analysis
Prospective observational studies or registries

Level C: Expert Opinion
Observational studies – epidemiologic findings
Safety reporting from large-scale use in practice

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Heart Failure Society of America (HFSA) Guideline Committee sought resolution of difficult cases through consensus building. Written documents were essential to this process, because they provided the opportunity for feedback from all members of the group. On occasion, consensus of Committee opinion was sufficient to override positive or negative results of almost any form or prior evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

"Is recommended": Part of routine care
Exceptions to therapy should be minimized.

"Should be considered": Majority of patients should receive the intervention.
Some discretion in application to individual patients should be allowed.

"May be considered": Individualization of therapy is indicated

"Is not recommended": Therapeutic intervention should not be used

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The process of moving from ideas of recommendations to a final document includes many stages of evaluation and approval. Every section, once written, had a lead reviewer and 2 additional reviewers. After a rewrite, each section was assigned to another review team, which led to a version reviewed by the Committee as a whole and then the Heart Failure Society of America (HFSA) Executive Council, representing 1 more level of expertise and experience. Out of this process emerged the final document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The strength of evidence (A, B, C) and strength of recommendations are defined at the end of the "Major Recommendations" field.

Elderly Patients with Heart Failure (HF)

- As with younger patients, it is recommended that elderly patients, particularly those age >80 years, be evaluated for HF when presenting with symptoms of dyspnea and fatigue. (Strength of Evidence = C)
- Beta-blocker and angiotensin-converting enzyme (ACE) inhibitor therapy is recommended as standard therapy in all elderly patients with HF due to left ventricular (LV) systolic dysfunction. (Strength of Evidence = B) In the absence of contraindications, these agents are also recommended in the very elderly (age > 80 years). (Strength of Evidence = C)
- As in all patients, but especially in the elderly, careful attention to volume status, the possibility of symptomatic cerebrovascular disease, and the presence of postural hypotension is recommended during therapy with ACE inhibitors and beta-blockers. (Strength of Evidence = C)

HF in Women

- Beta-blocker therapy is recommended for women with HF from:
 - symptomatic LV systolic dysfunction (Strength of Evidence = B)
 - asymptomatic LV systolic dysfunction (Strength of Evidence = C)
- ACE inhibitor therapy is recommended as standard therapy in all women with symptomatic or asymptomatic LV systolic dysfunction. (Strength of Evidence = B)

HF in African Americans

- Beta-blockers are recommended as part of standard therapy for African Americans with HF due to:
 - symptomatic LV systolic dysfunction (Strength of Evidence = B)
 - asymptomatic LV systolic dysfunction (Strength of Evidence = C)
- ACE inhibitors are recommended as part of standard therapy for African-American patients with HF from symptomatic or asymptomatic LV systolic dysfunction. (Strength of Evidence = C)
- Angiotensin-receptor blockers (ARBs) are recommended as substitute therapy for HF in African Americans intolerant of ACE inhibitors. (Strength of Evidence = B)
- A combination of hydralazine and isosorbide dinitrate is recommended as part of standard therapy in addition to beta-blockers and ACE-inhibitors for African Americans with LV systolic dysfunction and:
 - New York Heart Association class III or IV HF (Strength of Evidence = A)
 - New York Heart Association class II HF (Strength of Evidence = B)

Definitions:

Strength of Evidence

Level A: Randomized, Controlled, Clinical Trials
May be assigned based on results of a single trial

Level B: Cohort and Case-Control Studies
Post hoc, subgroup analysis, and meta-analysis
Prospective observational studies or registries

Level C: Expert Opinion
Observational studies – epidemiologic findings
Safety reporting from large-scale use in practice

Strength of Recommendations

"Is recommended": Part of routine care
Exceptions to therapy should be minimized.

"Should be considered": Majority of patients should receive the intervention.
Some discretion in application to individual patients should be allowed.

"May be considered": Individualization of therapy is indicated

"Is not recommended": Therapeutic intervention should not be used

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations").

The recommendations are supported by randomized controlled clinical trials, cohort and case-control studies, and expert opinion.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of heart failure in special populations (e.g., elderly, women and African Americans)

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

It must be recognized that the evidence supporting recommendations is based largely on population responses that may not always apply to individuals within the population. Therefore, data may support overall benefit of 1 treatment over another but cannot exclude that some individuals within the population may respond better to the other treatment. Thus guidelines can best serve as evidence-based recommendations for management, not as mandates for management in every patient. Furthermore, it must be recognized that trial data on which recommendations are based have often been carried out with background therapy not comparable to therapy in current use. Therefore, physician decisions regarding the management of individual patients may not always precisely match the recommendations. A knowledgeable physician who integrates the guidelines with pharmacologic and physiologic insight and knowledge of the individual being treated should provide the best patient management.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards
Slide Presentation

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Heart Failure Society of America. Management of heart failure in special populations. J Card Fail 2006 Feb; 12(1):e115-9. [50 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 (revised 2006 Feb)

GUIDELINE DEVELOPER(S)

Heart Failure Society of America, Inc - Disease Specific Society

SOURCE(S) OF FUNDING

Heart Failure Society of America, Inc

GUIDELINE COMMITTEE

Comprehensive Heart Failure Practice Guideline Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members and reviewers from the Executive Council received no direct financial support from the Heart Failure Society of America (HFSA) or any other source for the development of the guideline. Administrative support was provided by the Heart Failure Society of America staff, and the writing of the document was performed on a volunteer basis by the Committee. Financial relationships that might represent conflicts of interest were collected for all members of the Guideline Committee and of the Executive Council, who were asked to disclose potential conflicts and recuse themselves from discussions when necessary. Current relationships are shown in Table 1.5 of the "Development and Implementation" companion document (see the "Availability of Companion Documents" field).

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GUIDELINE AVAILABILITY

Electronic copies: Available from the [Heart Failure Society of America, Inc. Web site](#).

Print copies: Available from the Heart Failure Society of America, Inc., Court International - Suite 240 S, 2550 University Avenue West, Saint Paul, Minnesota 55114; Phone: (651) 642-1633

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Heart Failure Society of America. Executive summary: HFSA 2006 comprehensive heart failure practice guideline. J Card Fail 2006 Feb; 12(1): 10-38.
- Heart Failure Society of America. Development and implementation of a comprehensive heart failure practice guideline. J Card Fail 2006 Feb; 12(1): e3-9.
- Heart Failure Society of America. Conceptualization and working definition of heart failure. J Card Fail 2006 Feb; 12(1): e10-11.

Electronic copies: Available from the [Heart Failure Society of America, Inc. Web site](#).

- PowerPoint slides. HFSA 2006 comprehensive heart failure guideline.

Electronic copies: Available from the [Heart Failure Society of America, Inc. Web site](#).

The following is also available:

- Heart Failure Society of America. Pocket guide. HFSA 2006 comprehensive heart failure practice guideline.

Electronic copies: Not available at this time.

Print copies: Available from the Heart Failure Society of America, Inc., Court International - Suite 240 South, 2550 University Avenue West, Saint Paul, Minnesota 55114; Phone: (651) 642-1633

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 31, 2006. The information was verified by the guideline developer on August 10, 2006.

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